Purpose

A Personal Support Plan (PSP) identifies the supports and services that are necessary to achieve independence, dignity and personal fulfillment for the individual in Developmental Disabilities services. The Personal Support Plan ensures the person's services are designed to meet the individual's desires.

Personal Support Plan (PSP) Team

The team must consist of:

1. The individual in service;
2. A State Certified Case Manager/Qualified Mental Retardation Professional QMRP);
3. Representative for each provider agency serving the person; and
4. Guardian(s), if court appointed.

Other team members may include:

1. Family;
2. Friends;
3. Quality Improvement Specialist; or
4. Anyone else the individual wants to invite.

Personal Support Plan (PSP) Implementation

A Personal Support Plan (PSP) must be developed by the team with the individual in service within 30 calendar days of the person's entry into a service program or when a person moves from services in one community to services in another community.

The Annual Personal Support Planning meeting must be conducted with the individual, with assistance from the team within 365 calendar days or less from the individual's last Annual meeting. The first calendar day after the Personal Support Planning meeting is completed is the effective date of the Annual Personal Support Plan.

Personal Support Plan (PSP) Timelines

- Case Manager/Qualified Mental Retardation Professional (QMRP) will send an invitation to the Personal Support Planning team 30 calendar days prior to the Personal Support Planning meeting.

- Case Manager and Qualified Mental Retardation Professional (QMRP) must meet with the individual, and preferably with the individual's team, no later than 30 calendar days prior to the Personal Support Planning meeting to assist the individual in developing the individual's Vision statements.

- Providers are responsible for completing and sending the Case Manager an up-dated "Lifestyle" and "Wellness" section detailing service(s) provided to the individual 30 calendar days, prior to the Personal Support Planning meeting.

- Case Manager/QMRP must incorporate up-dated sections into the Personal Support Planning document, that come in throughout the year and forward those sections to the entire team within 10 working days from the time they were received.

- The Case Manager/QMRP will place the information sent from the provider into a blank Personal Support Plan in order to create an up-dated document for the scheduled Personal Support Planning meeting. The up-dated document minus the "Outcome Pages" must be sent to the Personal Support Planning team members 15 calendar days prior to the meeting.

- The Case Manager/QMRP must receive the "Implementation Strategies" within 10 working days after the Personal Support Planning meeting.

- "Implementation Strategies" associated with an Action that involve aversive procedures as outlined in the Developmental Disabilities Aversive Rule must be approved prior to any Personal Support Planning meeting.

- Following the Personal Support Planning meeting, all members of the team must receive the complete document within 15 working days after the Personal Support Planning meeting.

Assessments

A. The following assessments must be completed by the Case Manager/QMRP:
   1. Vulnerability Assessments are to be completed with the individual in services by the Case Manager/QMRP when the Individual enters services, reviewed annually and updated when necessary;
   2. Risk Factor for Health and Safety Form completed yearly by the Case Manager/QMRP;

B. The following assessments must be completed by the Provider(s) assessments must include but are not limited to the following:
   1. Health Care Checklist, completed yearly
   2. Living Skills - within 60 calendar days prior to the PSP meeting by the provider agencies providing services to the individual;

3. Developmental - within 60 calendar days prior to the PSP meeting by the provider agencies providing services to the individual;
4. Educational - within 60 calendar days prior to the PSP meeting by the provider agencies providing services to the individual;
5. Employment - within 60 calendar days prior to the PSP meeting by the provider agencies providing services to the individual;
6. Social or Leisure - within 60 calendar days prior to the PSP meeting by the provider agencies providing services to the individual;
7. Any other assessment(s) the team deems necessary.

C. Providers are responsible for seeing that the following medical assessments are completed:
   1. Physical - Yearly, unless otherwise recommended by the individual's physician;
   2. Dental - Yearly, unless otherwise recommended by the individual's dentist;
   3. Hearing - completed at appropriate intervals as determined by the health professional
   4. Vision - completed at appropriate intervals as determined by the health professional

Vision

The "Vision" is the focal point for the entire plan! It provides a picture of what the person envisions for the future and may include the following: where they want to live or work, what they would like to learn, what social opportunities they would like to be involved in or what interests they may wish to pursue. The "Vision" may be written for a one to three year period and may be written in a narrative statement or in short phrases. "Actions", "Outcomes" and "Implementation Strategies" must relate to the Personal Support Plan "Vision" statement.

Outcomes

Define what the person wants to accomplish or have happen. They are written in the Persons own words and are directly related to the person's "Vision" and must be agreed upon by the person whose plan it is, when appropriate. They are not service driven but reflect the outcome of the service or support. They are not always achieved in measurable and quantifiable ways. If it is determined that they need to be measurable to assure progress an "Implementation Strategy" may be developed.

Actions

"Actions" support the achievement of an "Outcome" and are developed at the Personal Support Planning meeting by the team. "Actions" list the specific and sequential steps required to accomplish the outcomes. "Actions" answer the questions: "How do I get there?" and "How will it be accomplished?"

"Actions" must include the following:

1. The name of the provider agency, the job title of the person responsible for completing each "Action". Otherwise the name of the person, who is not provider staff, who is responsible for the "Action";
2. A complete schedule which details how often the "Action" will occur (daily, weekly, monthly) and the purpose of the "Action".
3. A notation in the "Action" if an 'Implementation Strategy" is necessary.
4. The date written for the start and completion of the "Action" under the column for start and completion dates.

Implementation Strategies

"Implementation Strategies/Plans" are developed after the meeting by the responsible party in order to complete the Action. "Implementation Strategies" describe those things the individual will need to learn in order to achieve an "Outcome". They are written when the person is expected to learn a skill or accomplish something to assist the person in achieving a desired "Outcome". "Implementation Strategies" are developed based on formats designed by the Provider.

Implementation Strategies must include:

1. Task analysis;
2. Collection of data;
3. Measurable objectives which must contain:
    a. Statement of condition;
    b. Observable and measurable behavior;
    c. The criterion;
    d. The method for collecting data.
4. The method for recording progress should have sufficient information to determine the accomplishment of the "Implementation Strategy".

Implementation Strategies must be completed when:

1. Self-Administration of medication is required;
2. Career Plan is required for Supported Employment;
3. Rights restriction is in place; and
4. Behavior plan needs to be followed.

Implementation Strategies may also include:

1. Checklists;
2. Data collection sheets;
3. Progress charts;
4. Graphs; or
5. Any other materials developed by the responsible person to demonstrate progress.

All "Implementation Strategies" must be attached to the Case Manager and Provider copy of the Personal Support Plan. A legal guardian may request a copy of the "Implementation Strategies". Quality Improvement Specialists will review a sample of the plans at the time of the Annual Quality Assurance Review and may request copies of the "Implementation Strategies" at any time prior to the annual Quality Assurance review.

Amending the Personal Support Plan (PSP)

An amendment to a Personal Support Plan must be completed by the "decision making team" within 30 calendar days when a change to the original document is required. This includes changing a "Vision" statement or any "Actions" or "Outcomes". Changes to the "Outcome Page" must be initiated and disseminated by the Case Manager/QMRP, If a meeting is needed the Case Manager/QMRP will schedule and facilitate the meeting with those members needed to implement the change.

An amendment to the Personal Support Plan must be completed and a meeting scheduled when:

- The Individual Cost Plan (ICP) needs revision
- The individual is exiting services

Decision Making

Decisions about the Personal Support Plan are made by the service providers (providing the services needed), the individual in services, his/her legal guardian and the Case Manager/QMRP and other team members as appropriate. Decisions are based on what the person's vision for the future is and what supports the provider is able to offer towards achievement of the person's "Vision". Health and safety of the service recipient must be assured and must be considered in the decision making process.

When making decisions the Personal Support Planning team members must take into account:

1. The Individual's Rights, Developmental Disabilities Policy #01.03.411
2. The Montana Resource Allocation (MONA) for the individual;

3. The individual's cost plan (ICP) and;
4. The individual's health and safety needs.

Appeals

If the individual or their legal guardian wish to contest the Individual's Personal Support Plan they must:

1. Submit his/her issue or concern in writing to the Case Manager;
2. The Case Manager must submit the document to his/her Case Manager Supervisor for review and resolution, if within 5 working days the Supervisor is unable to resolve the issue;
3. The Case Manager Supervisor will forward the document to the Regional Manager for resolution within five working days;
4. The Regional Manager must respond in writing within 10 working days; If the individual or legal guardian are not satisfied with the Regional Manager's decision they may;
5. Submit the issue to the Planning Appeal Committee within 10 working days for further review;

The Planning Appeal Committee adopts its own procedures and timelines and will consist of:

1. An individual in services;
2. A parent, legal guardian/or advocate
3. A Case Manager;
4. A service provider; and
5. A representative of the Developmental Disabilities Program Central Office who is a voting member and responsible to coordinate and facilitate.

If the individual or their legal guardian is not satisfied with The Planning Appeal Committee's decision they may file an appeal with the Department of Public Health and Human Resources, "Office of Fair Hearing" and request a Fair Hearing.

Personal Support Plan (PSP) Quarterly Reports

In order to assess the effectiveness of the Personal Support Plan, Providers must submit quarterly status/progress reports to the Case Manager.

If Actions are not consistently being met the Case Manager needs to notify the Quality Improvement Specialist and the Regional Manager.

The quarterly schedule is based on the actual date of the Personal Support Planning meeting and the quarterly reports must be submitted every three months thereafter. However, it is allowable to submit quarterly reports based on the calendar year, that is:

1. January
2. April
3. July and;
4. October

If the Quarterly Reports are submitted on a calendar year schedule they must be received by the Case Manager before the 30th of January, April, July and October.

(1) For each person receiving services an individual plan status report must be produced on a quarterly basis.
  (a) Each corporation providing services for the person receiving service must assign a representative to participate in the development of the quarterly individual plan status report.
  (b) A copy of the individual plan status report must be provided to:
    (i) the Case Manager; and
    (ii) the Developmental Disabilities Program Office, If the Case Manager is a contracted Case Manager.
  (c) An individual plan status report must include the following:
    (i) a summary of progress toward the attainment of the objectives *("Action"/"Implementation Strategy")* listed in the individual plan.
    (ii) the need for or the action taken to assure progress; and
    (iii) the need if any, to reconvene the individual planning team.
  (d)The Case Manager will, depending on the individual plan status report;
    (i) discuss the information with an assigned representative from the Corporation;
    (ii) observe the implementation of objectives*("Actions"/"Implementation* Strategies")
    (iii) review individual progress data to determine if there is a sufficient lack of progress to necessitate notification of the individual planning team; and
    (iv) send individual plan status reports to other planning team members upon request.

(2) The individual planning team must meet at least annually to formally review the goals and objectives established at the previous planning meeting. In reviewing the previous plan, the team shall:
  (a) analyze progress data for each objective*("Action"/"Implementation Strategy")* selected at the last meeting;
  (b) modify the goals and objectives (*"Action"/"Implementation Strategy")* as necessary;
  (c) determine satisfaction with current services and supports; and
  (d) determine further services and supports that are needed.

Case Manager/Qualified Mental Retardation Professional (QMRP) Responsibilities

Case Managers and Qualified Mental Retardation Professionals (QMRP) are responsible for:

1. Writing the "Personal Introduction" section;
2. Meeting with the individual and his/her team to gather information for the "Personal Profile";
3. Composing the "Vision Page" after meeting with the individual and preferably his/her team;
4. Ensuring the "Signature Page" is completed after each meeting;
5. Incorporating the "Lifestyle", "Wellness" and "People Who Support Me" sections into a new Personal Support Planning document;
6. Ensuring the completion of all sections of the Personal Support Planning document and;
7. Meeting with the individual prior to the annual meeting to fill out the Interview with the Individual, the Risk Factor for Health and Safety Form, or any other form deemed necessary by the Developmental Disabilities Program.
8. Facilitating the annual Personal Support Planning meeting or any additional meeting.
9. The use of flip charts to facilitate the meeting unless it is refused by the individual in service.
10. Assisting the Individual in developing "Actions" and "Outcomes" that logically reflect back to the individual's "Vision" statements.
11. Transferring the information from the Personal Support Planning meeting onto the "Outcome Page" for dissemination to the entire team.
12. Ensuring that the planning process and the Personal Support Plan reflects the individuals health and safety needs.
13. If an Individual is in the Community Supports Waiver, Case Managers complete: the "General Information Page", "Personal Introduction", "Vision Page" and the "Outcome Page" and the "Signature Page" with assistance from the team.
14. If an individual is on the waiting list for services, Case Managers complete: the "General Information Page", the "Vision Page", the "Personal Introduction"; the "Outcome page"; and the "Signature Page".
15. If an individual wishes to receive only Case Management and is not on the Waiting list, Case Managers are responsible for completing the "Outcome Page".

Developmental Disabilities Program Provider Responsibilities

The Provider is responsible for:

1. Writing descriptive narratives in the "Lifestyle" and "Wellness" sections of the Personal Support Plan which explain in detail what the individual in services life looks like on a daily basis;
2. Updating the "Lifestyle" and "Wellness" section as needed when the individual's information changes;
3. Filling out the "Financial Page";
4. If an individual is in the Community Supports Waiver, the provider agency completes:

(a) the "Life Style" sections that apply to the services being provided;
(b) "Wellness" section that apply to the services being provided;
(c) Medications that apply to the services being provided;
(d) Allergies/sensitivities that apply to the services being provided;
(e) Equipment, supplies and technology that apply to the services being provided;
(f) People who support me that apply to the services being provided; and
(g) the "Outcome Page" with assistance from the team.

5. For preparing and submitting quarterly status/progress notes to the Case Manager on the "Outcome Page" next to the corresponding "Action" according to the quarterly dates established at the Personal Support Planning meeting. Quarterly status/progress notes are entered in consecutive order thus documenting the succession of progress; and
6. Documenting the progress of the individual by detailing the progress of the "Implementation Strategy" specified in the "Action".

Director, Developmental Disabilities Program — Date: 7-20-09

Web Manager, DDP — Date: 7/20/09